



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH OF SOUTHWEST FORT WORTH
3255 W PIONEER PKWY
ARLINGTON TX 76013

Respondent Name

Wal Mart Associates Inc

Carrier's Austin Representative Box

Box Number 53

MFDR Tracking Number

M4-12-1940-01

MFDR Date Received

February 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The correct allowable due is \$3,325.75, minus their payment of \$2,494.48 there is still an outstanding balance of \$831.27."

Amount in Dispute: \$831.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "THE PREVIOUSLY PAID REIMBURSEMENT HAS BEEN CORRECTLY CALCULATED & IS NOT SUBJECT TO OUTLIER PAYMENT IN ACCORDANCE WITH 2011 CMS OPPS CALCULATION METHODOLOGY. HOWEVER, ADDTL PMNT IS DUE TO PROVIDER FOR CPT 71010 APC 260 IN AMOUNT OF \$87.70 WITH INTEREST OF \$0.73 FOR TOTAL PMNT OF \$88.43."

Response Submitted by: Hoffman Kelley LLP

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2011	Outpatient Hospital Services	\$831.27	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 24, 2011

- 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED.
- 86 – SERVICE PERFORMED WAS DISTINCT OR INDEPENDENT FROM OTHER SERVICES PERFORMED ON THE SAME DAY.
- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT WAS ALREADY BEEN ADJUDICATED.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- 289 – THE RECOMMENDED ALLOWANCE IS BASED ON THE VALUE FOR THE TECHNICAL COMPONENT OF THE SERVICE PERFORMED.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPTS SCHEDULE ALLOWANCE.
- 847 – IN ACCORDANCE WITH OPPTS GUIDELINES, THE BILLED REVENUE CODES REQUIRES HCPC/CPT CODING. NO SEPARATE PAYMENT IS RECOMMENDED FOR A NON-PACKAGE REVENUE CODE.
- 5036 – Complex Bill – Reviewed by Medical Cost Analysis Texas – UR/JE

Explanation of benefits dated February 23, 2012

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPTS SCHEDULE ALLOWANCE.
- 1001 – BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/JE

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
 - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services

for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$14.87. 125% of this amount is \$18.59

- Procedure code 84703 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.57. 125% of this amount is \$13.21
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$10.94. 125% of this amount is \$13.67
- Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.
- Procedure code 72070 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.
- Procedure code 72100 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.
- Procedure code 72170 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.
- Procedure code 73030 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.

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related amount of \$25.83. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$43.85. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$43.85. This amount multiplied by 200% yields a MAR of \$87.70.

- Procedure code 72125 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 70450 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8005. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 96374 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.13. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$21.16. The non-labor related portion is 40% of the APC rate or \$14.75. The sum of the labor and non-labor related amounts is \$35.91. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$35.91. This amount multiplied by 200% yields a MAR of \$71.82.
- Procedure code 96375 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0437, which, per OPPS Addendum A, has a payment rate of \$36.88. This amount multiplied by 60% yields an unadjusted labor-related amount of \$22.13. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$21.16. The non-labor related portion is 40% of the APC rate or \$14.75. The sum of the labor and non-labor related amounts is \$35.91. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$35.91. This amount multiplied by 200% yields a MAR of \$71.82.
- Procedure code 96376 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC if OPPS criteria are met; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$127.69. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$216.72. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$216.72. This amount multiplied by 200% yields a MAR of \$433.44.
- Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 72125, and 70450 have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8005, for computed tomography (CT) services without contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 8005, which, per OPPS Addendum A, has a payment rate of \$420.85. This amount multiplied by 60% yields an unadjusted labor-related amount of \$252.51. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of \$241.42. The non-labor related portion is 40% of the APC rate or \$168.34. The sum of the labor and non-labor related amounts is \$409.76. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$409.76. This amount multiplied by 200% yields a MAR of \$819.52.

The total allowable reimbursement for the services in dispute is \$2,582.17. This amount less the amount previously paid by the insurance carrier of \$2,582.91 leaves an amount due to the requestor of \$0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

June 10, 2013
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.